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### Deposited in DRO:

11 April 2017

### Version of attached file:

Published Version

### Peer-review status of attached file:

Unknown

### Citation for published item:

Brown, J. and Hunter, D.J and Marks, L. and Salway, S. and Gray, J. and McCafferty, S. and Payne, N. and Peckham, S. and Thokala, P. and Vale, L. (2016) 'Shifting the gravity of spending? results of a national survey of selected members of Health and Wellbeing Boards.', Project Report. Durham University, School of Medicine, Pharmacy Health, Durham.

### Further information on publisher's website:

<https://www.dur.ac.uk/public.health>

### Publisher's copyright statement:

### Additional information:

The research was funded by the NIHR School for Public Health Research (SPHR).

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# Shifting the gravity of spending?

Results of a national survey of selected  
members of Health and Wellbeing Boards

March 2016

Funded by  
**NHS**  
National Institute for  
Health Research

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Peckham, S., Thokala, P., Vale, L.

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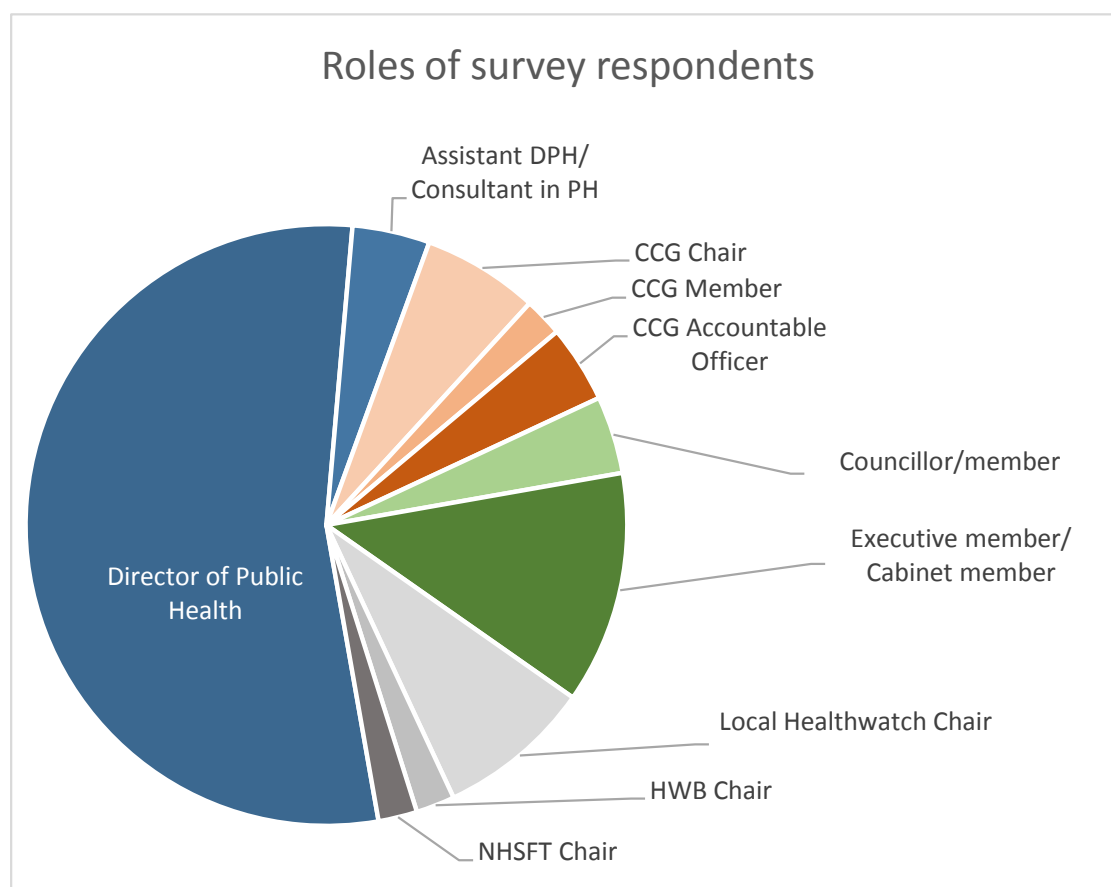
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*The research was funded by the NIHR School for Public Health Research (SPHR). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.*

## 1 Introduction

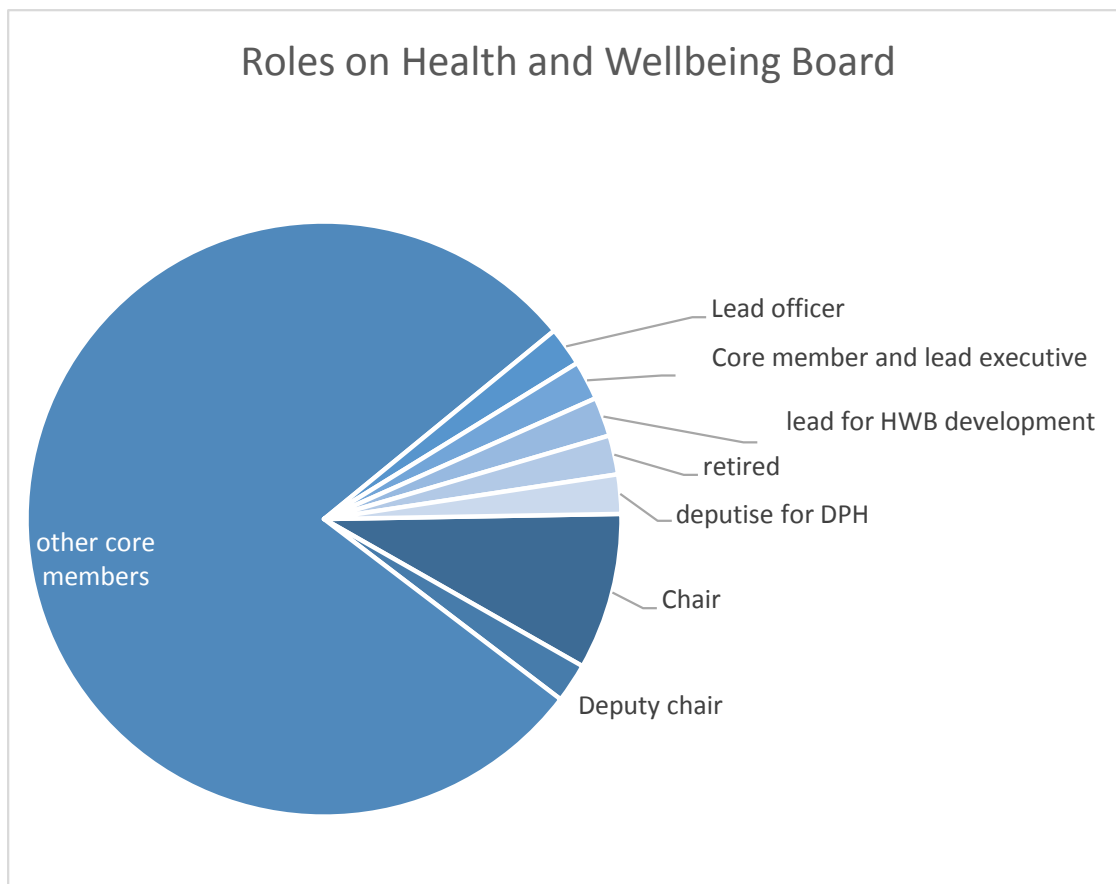
A national survey was carried out in autumn 2014, using Bristol Online Surveys , to collect the views of selected core members of Health and Wellbeing Boards (HWBs) across England. Invitations to complete the survey were sent to 610 members of HWBs. Overall, after repeated follow-ups, there were 47 responses received between 30<sup>th</sup> September 2014 and 1<sup>st</sup> December 2014 (a 7.7% response rate). Of the 47 respondents, 28 (58%) were senior public health professionals, eight (14%) were councillors or executive/cabinet members and six (13%) were senior CCG professionals (see Figure 1). Given the low response rate, the results of this survey do not allow for generalisation.

Figure 1: roles of survey respondents



With regard to roles on the HWBs, 79% of respondents were core members and 11% were chairs or deputy chairs (see Figure 2).

Figure 2: respondents' roles on Health and Wellbeing Board



The survey contained questions on the following topics:

- the levels of influence over public health spending
- local public health priorities
- criteria for public health spending
- prioritisation techniques and decision-support methods
- the allocation of the ring-fenced public health budget
- decision-making for public health spending
- barriers to public health spending
- the effects of the transfer of public health responsibilities.

The findings relating to each of these topics are presented below.

## 2 Influence over public health spending

### 2.1 Influence of the Health and Wellbeing Board in prioritising spending

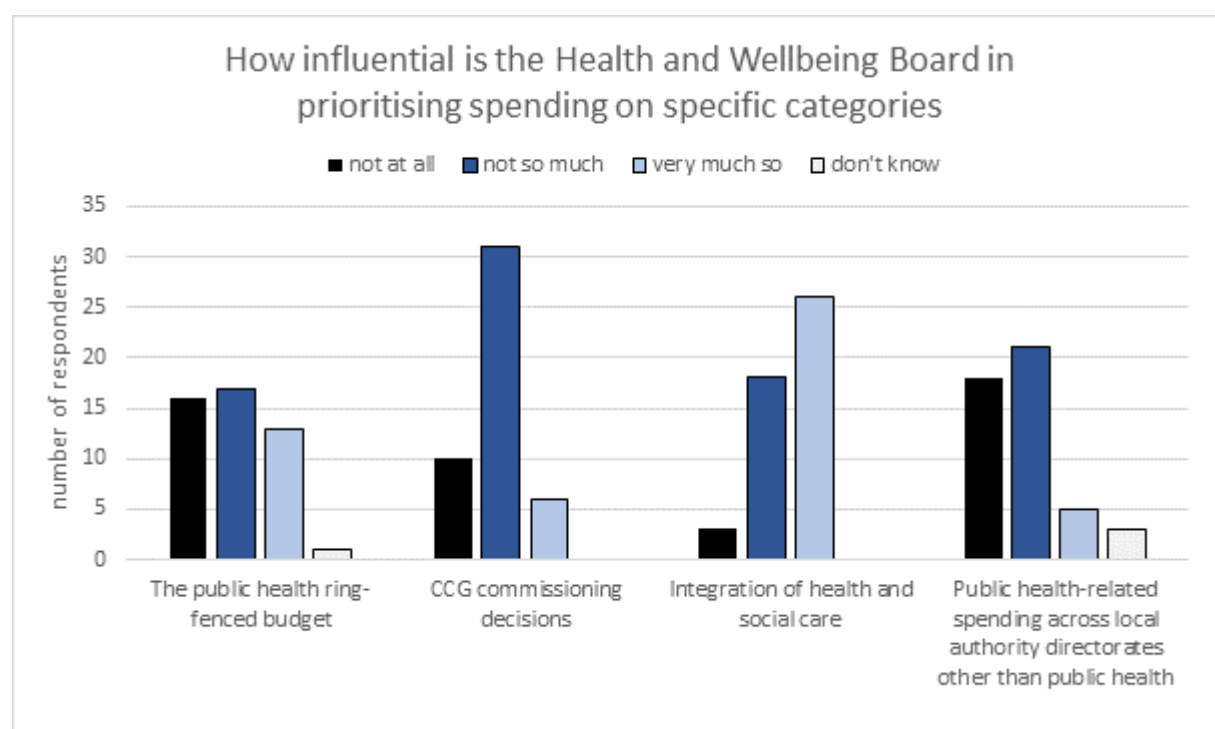
As can be seen from Figure 3, there is no agreement amongst respondents as to the level of influence the HWB has in prioritising spending for the public health ring-fenced budget.

With regard to CCG commissioning decisions, 21% of respondents felt that the HWB was not at all influential in prioritising spending, 66% felt it did not have much influence and only 13% felt it had a lot of influence.

The picture was rather different for prioritising spending on the integration of health and social care, where 55% of respondents said the HWB was very influential and only 6% thought it not at all influential.

The influence of the HWB in prioritising public health-related spending across local authority directorates other than public health appears to be low, with 38% of respondents saying it was not at all influential and only 11% saying it was very influential.

Figure 3: influence of Health and Wellbeing Board in prioritising spending



Respondents were asked for examples of how the HWB influences public health spending across local authority directorates other than public health. Of the 38 valid<sup>1</sup> responses, 3 said there were no such examples and another 10 stated categorically that the HWB did not influence such spending. Two said that the decisions were made by 'the council' and another said the spending was decided by the 'local authority finance team'.

Among the other 25 valid responses, there were some examples of both general influence and influence in specific projects. Examples of general influence included one respondent who felt that

<sup>1</sup> one response was 'ywedj' and 8 respondents did not answer the question.

'the HWB endorses Local Authority proposals to ensure public health spending across Directorates' and another who said that 'all policy documents come through HWB and are agreed'. Several respondents referred to the integrated commissioning agenda and the Health and Wellbeing Strategy as areas where the HWB had influence. Two others suggested that the HWB influenced spending by raising awareness or by putting on supporting seminars and public engagement opportunities. Another felt that the evidence collected in the Joint Strategic Needs Assessment (JSNA) influenced service planning and expenditure.

Some respondents added comments about the HWB in their reflections on the survey. One suggested that the HWB was not functional as it was very council driven and 'I certainly do not feel an equal partner'. It was further suggested that joint commissioning rendered the value of HWBs questionable.

Many of the more specific examples related to health and social care, rather than to other directorates (one respondent commented that the HWB was 'dominated by health and social care issues'.) However, other examples included

- the embedding of the principle of wellbeing across housing and economic development
- maintaining libraries and green spaces
- whole system approaches to physical activity, alcohol prevention programmes and winter warmth
- the obesity agenda influencing expenditure in schools and spending on sports/leisure
- spatial planning, with a joint appointment between public health and planning.

## 2.2 Range and extent of Health and Wellbeing Board influence in relation to public health

Respondents were asked how far they felt their HWB had fulfilled certain actions in relation to public health. Responses are shown in Figure 4.

There was no agreement about the level of influence HWBs had over public health spending priorities.

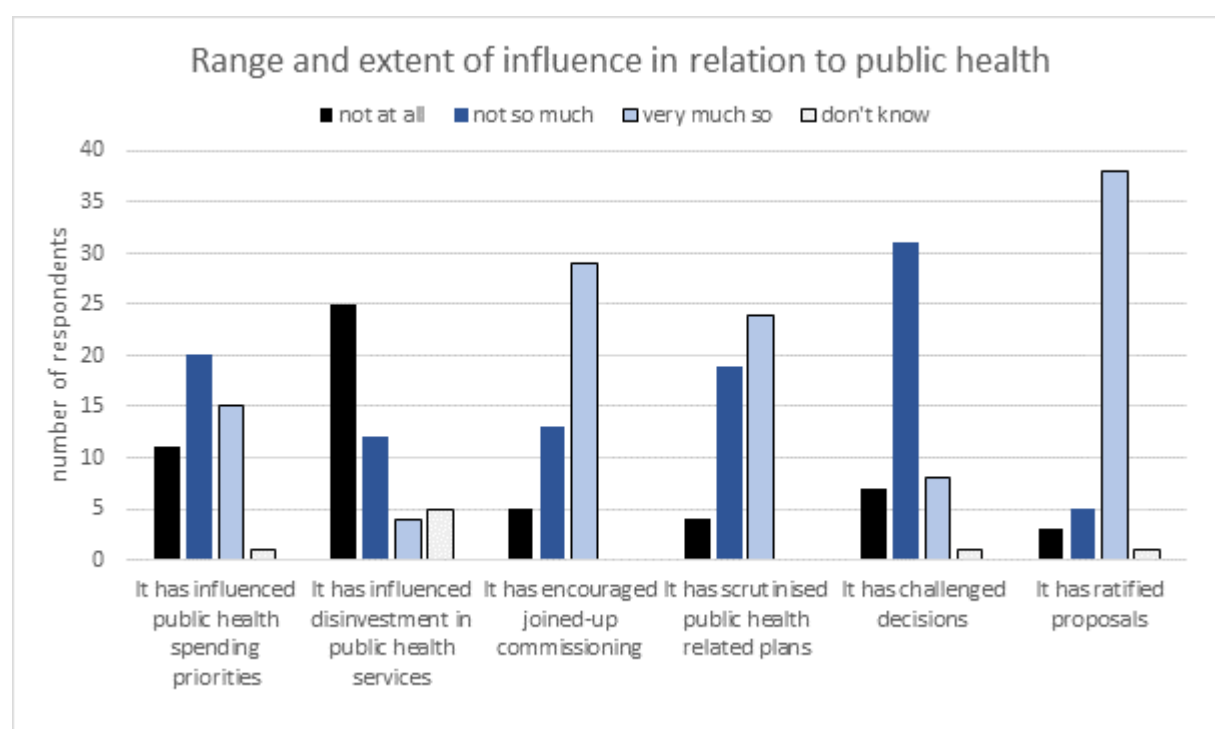
HWBs were felt by 80% of respondents to have had no or very little influence over disinvestment in public health services.

HWBs were said by 62% of respondents to have very much encouraged joined-up commissioning, with only 11% saying HWBs had not encouraged this at all.

Only 9% of respondents said that HWBs had not scrutinised public health related plans at all, whilst 51% said they had scrutinised them very much.

While 15% of respondents felt that the HWB had not challenged decisions at all, 17% felt the HWB had very much challenged decisions and 66% felt the HWB had challenged decision 'not so much'.

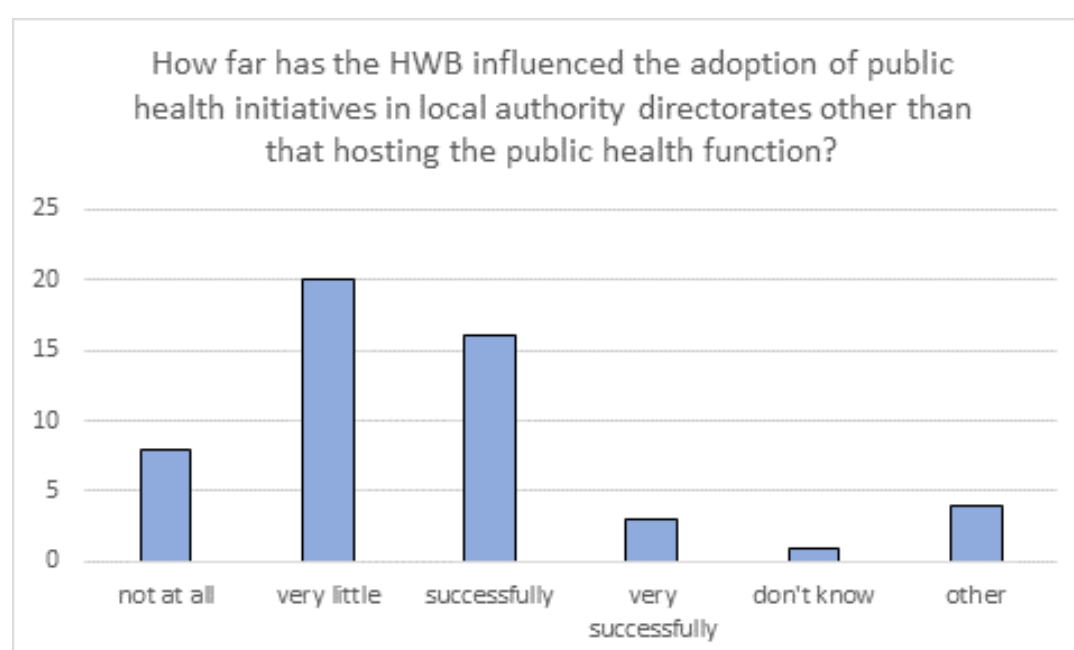
Figure 4: range and extent of influence of HWB in relation to public health



### 2.3 Influence of the Health and Wellbeing Board in other local authority directorates

Respondents were asked how far the HWB had influenced that adoption of public health initiatives in local authority directorates other than those hosting the public health function. Although 3 respondents felt it had done so 'very successfully' and 16 said 'successfully', 28 thought it had influenced this very little or not at all, as shown in Figure 5.

Figure 5: HWB influence in local authority directorates other than those hosting the public health function





One respondent commented that they followed the strategic objectives and another said that it was largely an internal process for the local authority. Another said that although the JSNA has had significant influence on adoption of public health initiatives in other local authority directorates, a lot of that happened before the HWB was in place.

## 2.4 Influence over Health and Wellbeing Board decisions

Respondents were asked how much influence they or their organisation were able to exert over HWB decisions. No respondents said they had none and only 6 said their influence was 'slight'; 36 felt the influence was 'considerable, 'great' or 'a great deal' (there were some criticisms about the options that respondents could tick for this question).

Whether or not the HWBs make decisions at all appears questionable in some cases, as shown in Box 1, which contains quotations from respondents.

*Box 1: decision-making abilities of Health and Wellbeing Boards*

'The HWB doesn't make decisions.'

'So far hardly any decisions of any value have been made.'

'Unfortunately our health and wellbeing board has not really made any decisions. It is more of a discussion forum. It has signed off the health and wellbeing strategy, but the content was decided elsewhere.'

'It is more about relationship-building and agenda-setting than actual decisions so far.'

Comments were also offered relating to the difficulties in influencing the Board, as shown in Box 2.

*Box 2: restricted ability to influence the Health and Wellbeing Boards*

'It is very much a "council" meeting and restricted by their bureaucracy and governance. I do not consider we are considered equal partners despite us holding a far greater budget!'

'Elected members are in the majority on the HWB – not that we make many decisions as the board has few powers.'

'CCG has recently been able to join the pre-agenda meetings but are still non-voting members.'

## 3 Public health priorities

### 3.1 Main public health priorities

Respondents were asked to state the main public health priorities their authority needed to address. There were many similarities among the different responses, with one respondent just saying ‘the same as everywhere else’. For instance, many mentioned smoking, alcohol misuse, obesity (including diet and physical activity) and mental health. Differences tended to be in the level of specificity of priorities mentioned: some were very broad (for example ‘tackling health inequalities’, ‘poverty’, ‘employment’, ‘opportunity’); some targeted specific age groups (for example ‘healthy ageing and independence’, ‘maximising the health of the diminishing adult workforce’, or ‘getting a good start in life’).

### 3.2 Potential investment and disinvestment

Respondents were asked whether they thought that potential investment in one or more of the public health priorities that they had indicated above would require disinvestment in services. One commented that ‘We are not investing in public health – only disinvesting’.

21 respondents answered ‘no’ (disinvestment would not be required) and another, who ticked the ‘other’ box, said ‘not at present, as efficiencies are gained from aligning services across 5 CCGs’. Service redesign also featured in another comment under the ‘other’ responses: ‘we are working across a number of areas of the Authority’s operation to redesign existing services to better meet health and wellbeing needs – e.g. neighbourhood structures and services, welfare rights and debt advice, youth services.’

The 16 respondents who answered ‘yes’ were invited to indicate what the main areas for disinvestment were. Responses are shown in Box 3.

*Box 3: main areas for disinvestment*

‘To meet the ACRA formula level to enable prudent and considered decisions about public health commissioned services.’

‘Those areas of activity that can and should be done by the NHS.’

‘The council would like to disinvest in public health consultants as they deem them an expensive resource!’

‘Within public health ring-fence: taking some spend out of smoking cessation services to fund wider tobacco control and health inequalities approach; taking some funding out of sexual health and dental health promotion to fund public mental health initiatives.’

‘Sexual health’ (two respondents, with another saying ‘possibly sexual health services’).

‘Sexual health and drug treatment services.’

‘I have planned to reduce investment in a number of services where we can get the same performance for less – these are being successfully reprocurd. This has released funding for other areas such as anti-poverty measures, improving the health of older people and supporting some of the public health work of other directorates that are at risk of removal or reduction, e.g. domestic

violence, housing support, school crossing patrols, transport.'

'Acute spend is the only area in a very tight budget.'

'Health trainers, NHS Health Checks, obesity, mental health, smoking cessation, dental public health.'

'Politically motivated services focused on activity with no discernible outcomes, we don't have the luxury!'

'Health trainers, health checks, most PH programmes are being cut but not to fund the priorities listed above.'

'Small projects with limited reach.'

'Commissioned services.'

'Some of the former PCT commissioned lifestyle services that were delivering in silos and didn't get to the root causes.'

'Individual approaches that are at an insufficient scale to impact on public health.'

'Council has gone beyond potential to make simple efficiencies to fund investment in priorities. Looking primarily at ways to mitigate impact of cuts which is necessitating funding acute needs in short term over prevention.'

'This may seem paradoxical (because it is!): sexual health services, community health improvement services, stop smoking services.'

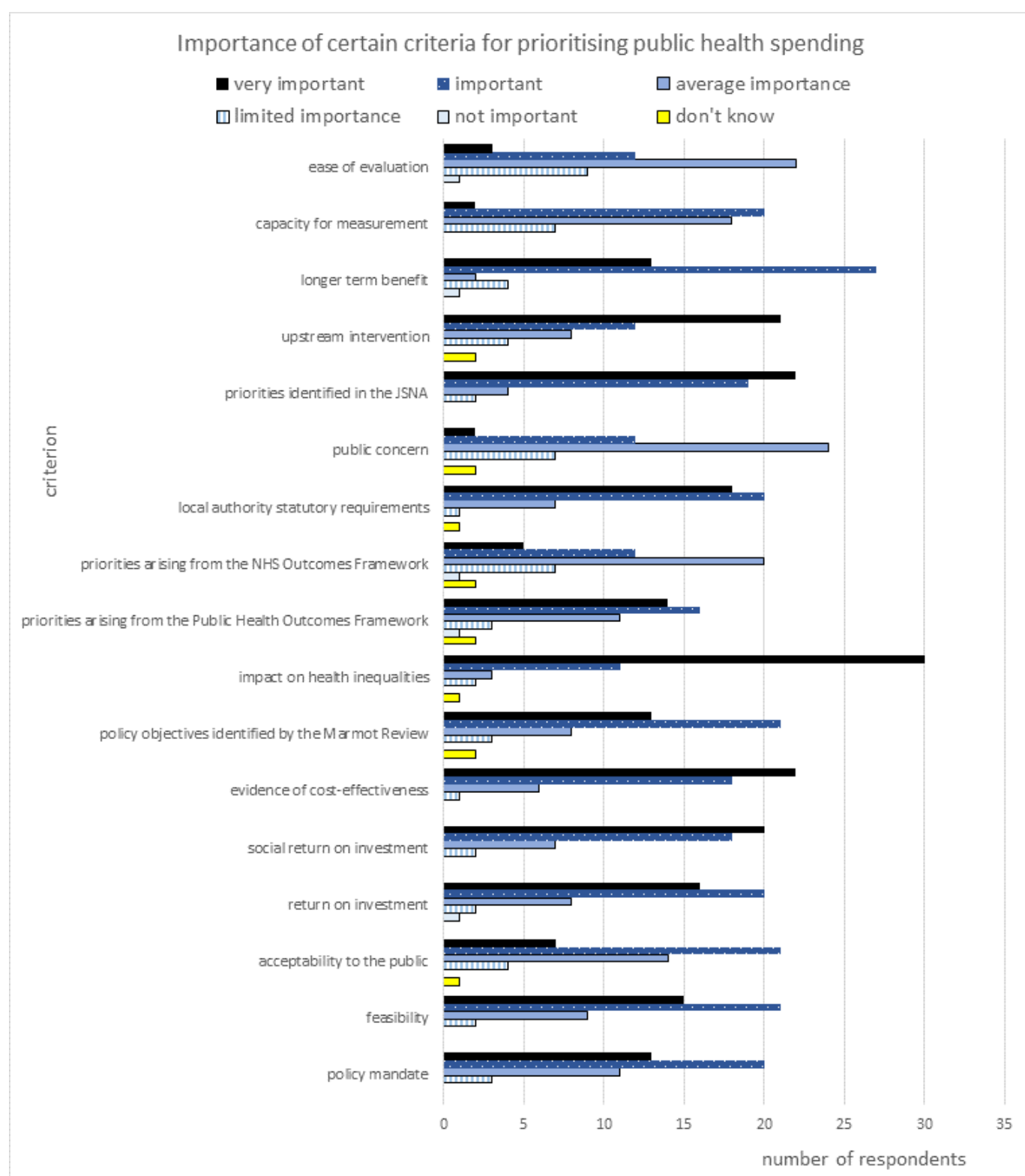
Among the 10 respondents who answered 'other', respondents' comments included criticism of the wording of the question: four felt they did not understand the question and one commented that the terminology was 'loaded (partisan)' because changing priorities do affect spending but 'this is not disinvestment'. Another comment reflected this idea that rather than 'disinvestment', it was a matter of thinking differently. In the 'reflections on the survey' section, one respondent commented that 'disinvestment is a pejorative and inappropriate term – priorities and spending patterns change and always have done!'

### 3.3 Importance of specific criteria for prioritising public health spending

Respondents were asked how they would assess the importance of specific criteria for prioritising public health spending.

As can be seen in Figure 6, the impact on health inequalities was deemed to be a very important criterion by the highest number of respondents. Evidence of cost-effectiveness, upstream interventions and JSNA priorities were also considered very important. Public concern, ease of evaluation and NHS Outcomes Framework priorities were commonly rated as of average importance.

Figure 6: importance of certain criteria for prioritising public health spending

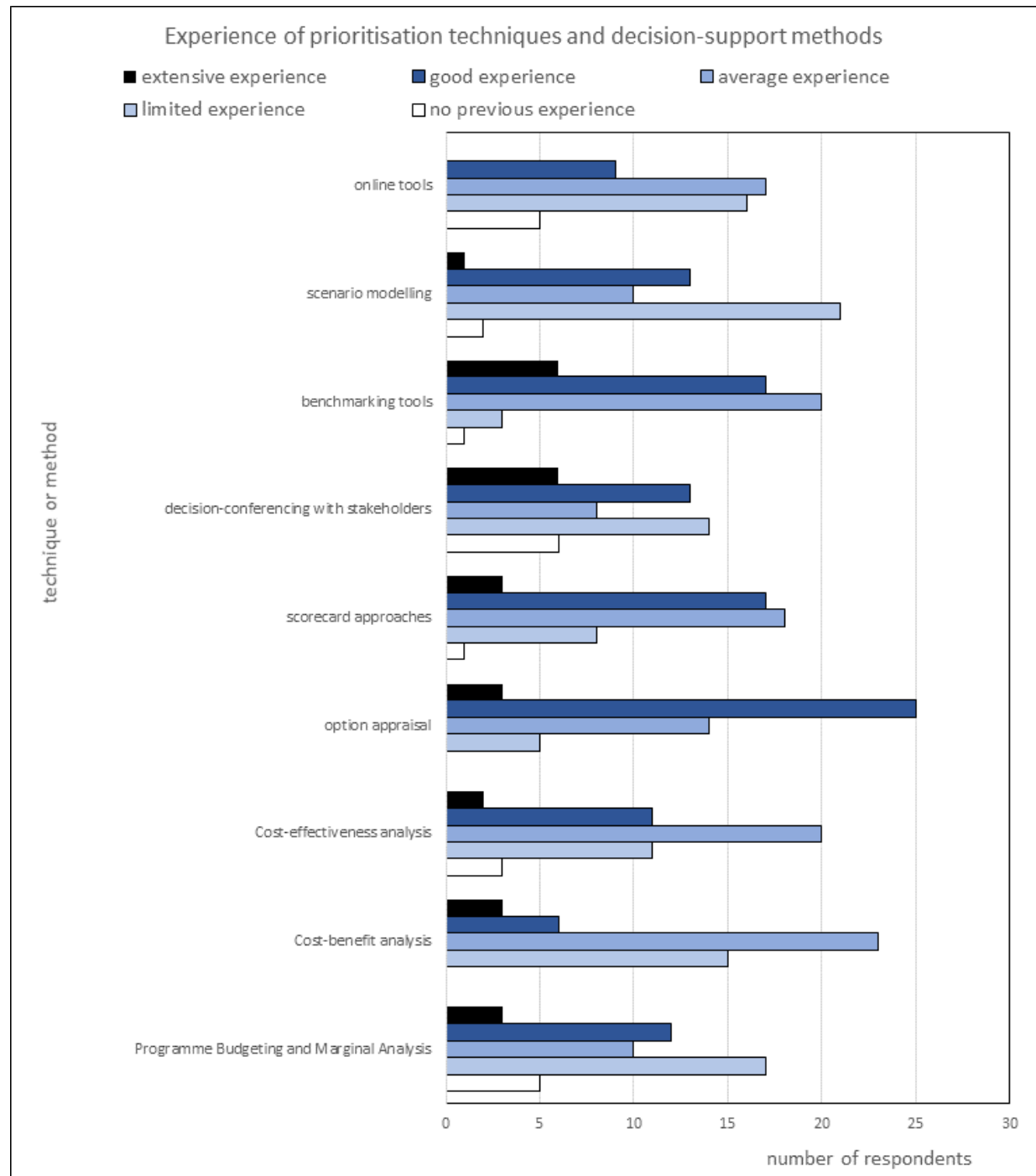


#### 4 Use of decision-support methods

Respondents were asked to indicate their levels of experience of a range of prioritisation techniques and decision-support methods. As can be seen in Figure 7, very few had extensive experience of any of the approaches: only in benchmarking tools and decision-conferencing with stakeholders were

there more than 5 respondents with extensive experience. Option appraisal was the method with the highest number of respondents claiming good experience, followed by benchmarking tools and scorecard approaches. On-line tools, scenario modelling, decision-conferencing and Programme Budgeting and Marginal Analysis (PBMA) all had high proportions of respondents with limited or no experience.

Figure 7: experience of prioritisation techniques and decision-support methods

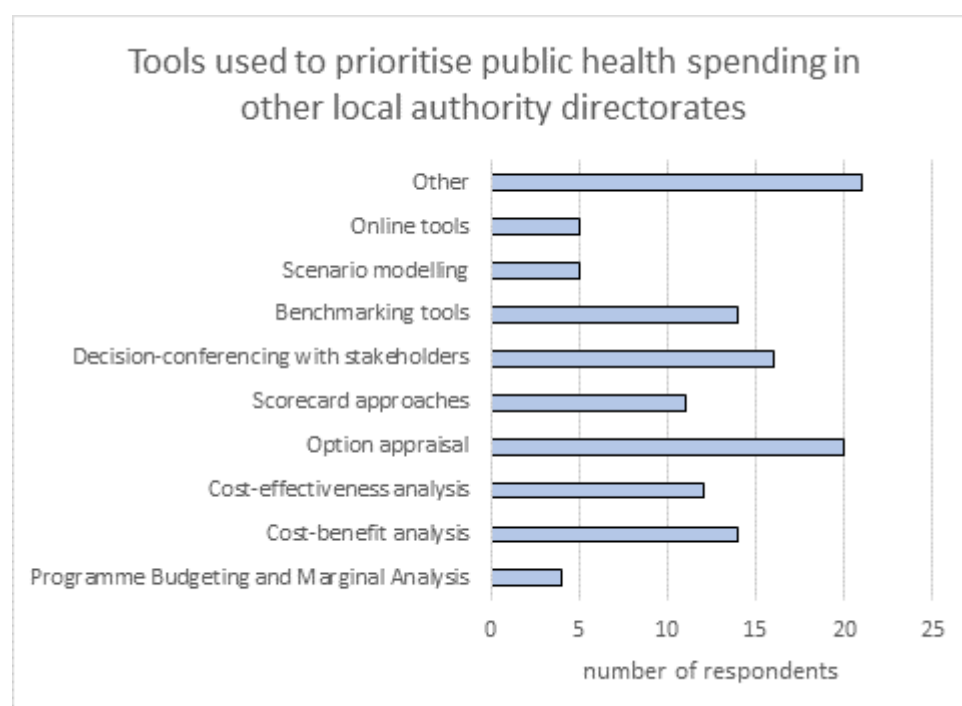


Respondents were asked whether any of a range of specific tools had been used to prioritise public health spending in local authority directorates other than public health. As can be seen from Figure 8, 'other' was ticked more than any of the named techniques, although 'option appraisal' was ticked by almost as many (20). It is worth noting that option appraisal was, as mentioned above, the

technique with which the most respondents had good experience. At the other end of the scale, online tools, scenario modelling and PBMA had been used by very few in the prioritisation of spending in other departments. These were the three where respondents had the least experience, as described above. Perhaps this begs the questions:

- Was option appraisal used because respondents were already experienced in its use, or did their experience come from its use in this prioritisation exercise? (Option appraisal is more common in a local authority context.)
- Were online tools, scenario modelling and PBMA deliberately used very little because of the lack of experience of respondents?

*Figure 8: tools used to prioritise public health spending in other local authority directorates*



Among the 21 responses of those who ticked 'other', only one indicated that other tools had been used: Sport England tools and maps re physical activity and the value of sport. Seven respondents did not know whether such tools had been used and seven said that no tools were used. One respondent suggested that the principles are more influential for elected members. One said that no objective approaches were used and that each director was responsible for their own approach to meet the political requirement of minimal change to services for residents. Another said that LA colleagues were not interested as they only wanted savings to minimise their own reductions. Another said there were formal consultations on politically acceptable proposals, an idea echoed in two responses to the effect that decisions were political, based on the potential to gain votes. In the 'reflections on the survey' section, one respondent said that local authorities were 'familiar with Value for Money but not with prioritisation'.

Over half of the respondents said there were no publicly available examples of prioritisation frameworks used in their HWB, local authority or CCG. Eight respondents did not know. Two said they could provide them on request. The specific examples that were provided were:

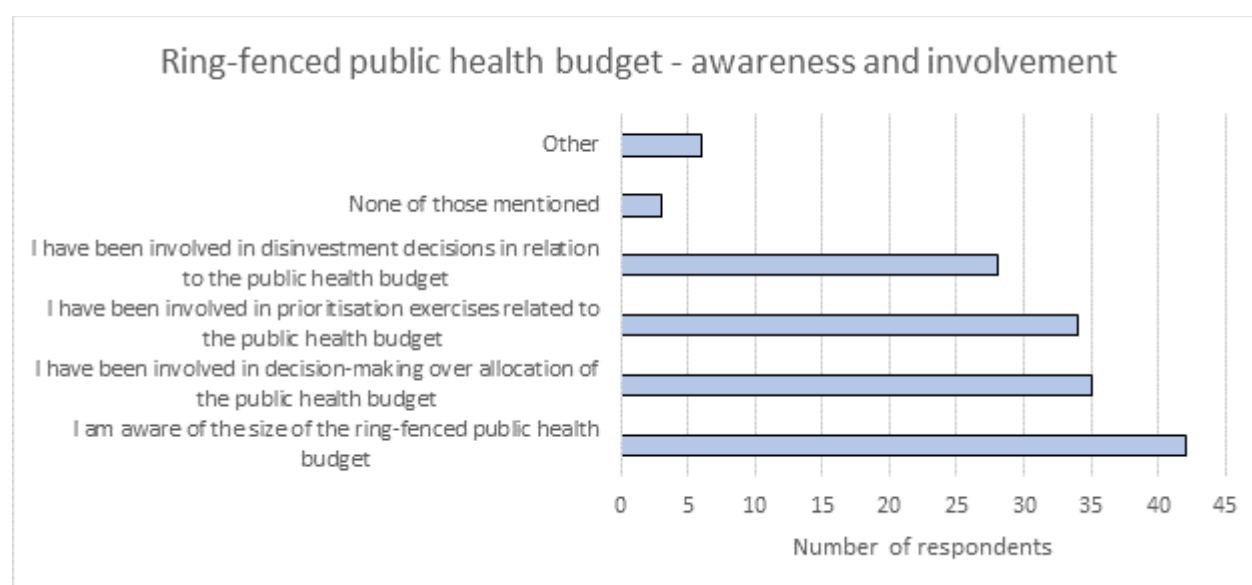
- JSNA papers brought to HWB
- Mental Health Strategy
- Best Start in Life; Dementia Strategy; Mental Health Strategy (all examples from one respondent)
- JSNA
- In Cabinet report on the Public Health Resource Fund
- Joint Health and Wellbeing Strategy 2012-17
- Medium term financial plan
- Prioritisation matrix
- Budget consultation via council website.

## 5 The allocation of the ring-fenced public health budget

### 5.1 Respondents' awareness of and involvement in the ring-fenced budget

As can be seen from Figure 9, levels of awareness of and involvement in the ring-fenced public health budget varied among respondents, who were asked to tick statements that applied to them. Whilst the majority of respondents were aware of the size of the ring-fenced budget, only 72% had been involved in prioritisation exercises related to it.

Figure 9: awareness of and involvement in ring-fenced public health budget



The comments from those who ticked 'other' are shown in Box 4.

Box 4: comments related to awareness and involvement in ring-fenced public health budget

'We have not been involved to date but new Interim DPH hopefully will change things.'

'Also looked at by our all-party Budget Strategy Group.'

'Major disinvestment has been avoided.'

In effect, involved in prioritisation, but basically there are a few big blighters and you have to cut some sacred fat to be able to do anything else.'

'Prioritisation does involve shifts in allocation of resources. Changes in provider arrangements would be a current feature.'

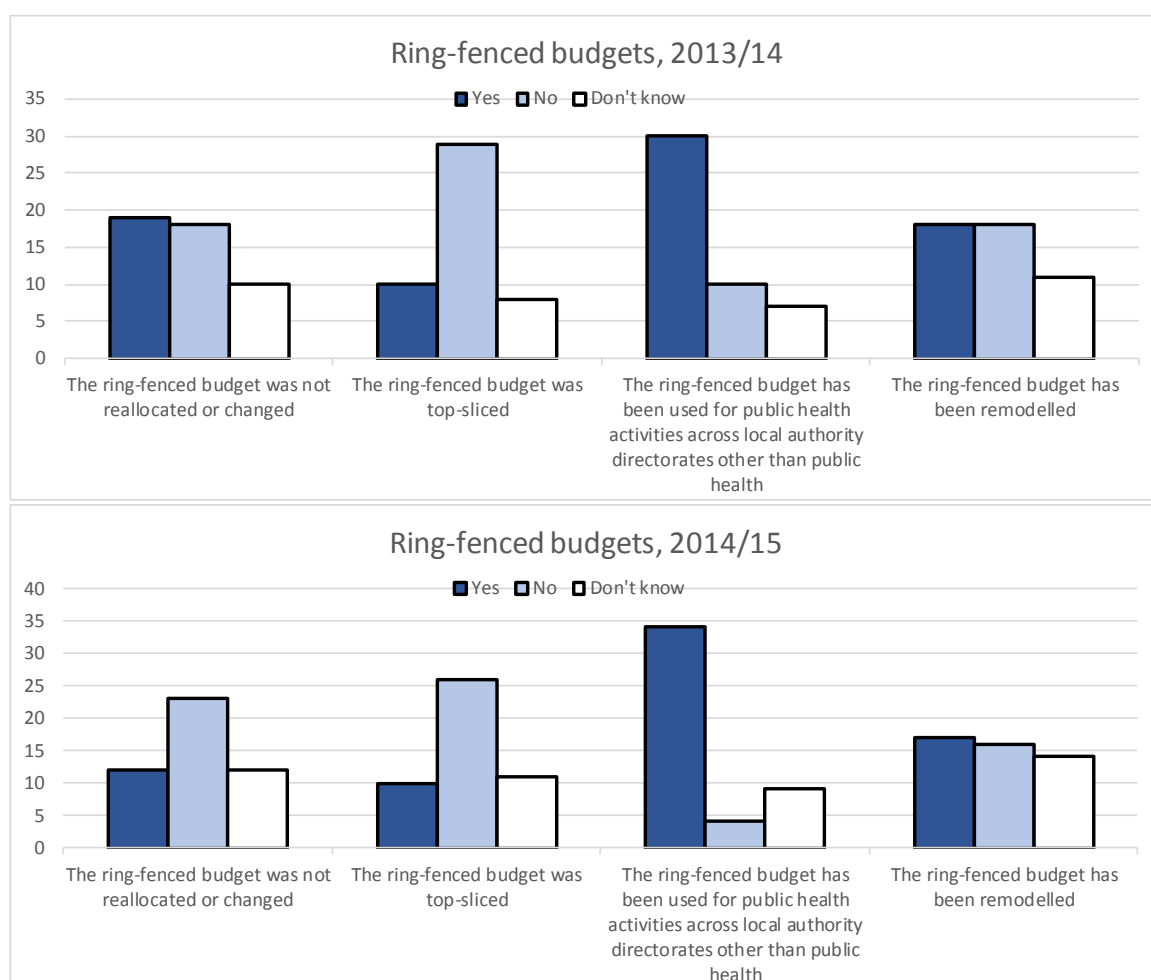
'Involved but with limited ability to influence.'



## 5.2 Use of and changes in the ring-fenced budgets

Figure 10 shows responses to the questions: ‘did any of the following apply to your host local authority in the financial year 2013-14?’ and ‘did any of the following apply to your host local authority in the financial year 2014-15?’ Responses vary somewhat between the two years. The ring-fenced budgets in 2014/15 were more likely to have been reallocated or changed and more likely to have been used for public health activities across local authority directorates other than public health.

Figure 10: use of and changes in the ring-fenced public health budget



Respondents were asked to provide brief descriptions of any of changes in the allocation of the budget of which they were aware. One commented that the budget had been protected for at least two years.

Several respondents expanded on the use of funding across the local authority. One said that ‘Funding has been made available to support the wider council with financial pressures, where a clear public health benefit can be identified and where reduction or removal of the service would impact on the health and wellbeing of local people. Agreement is through a public health led prioritisation process.’ Another said that Public Health was integrated within the Council with Leisure, Public Protection and Occupational Health & Safety, so funds from the public health budget

were used to support public health focused work in those areas on a managed basis. One respondent said that the funding was allocated to a range of local authority service areas that impact on public health, for example trading standards, parks, leisure centres, children's centres, communications, supported housing for people with a mental illness. There were also related points made in the 'reflections on the survey' as shown in Box 5.

*Box 5: spending of public health money by other departments*

'Significant sums from the PH grant are being used for services with a limited impact on public health at the expense of core services.'

'The other council departments use the PH monies without evidence or agreed outcomes.'

The top-slicing of the growth funding for overheads was said by one respondent to be reasonable, being similar to the amount of overheads transferred, and was used to fund public health related services in other directorates.

Not all of the funding was thought to be spent on public health-related issues: one respondent said 'not sure if fully spent on public health; another said that the funding was used for 'non public health uses'; and another stated that 'it meets the reporting criteria but funds other activities that provide politically desired services'; one reported 'money given to other directorates to fund existing services and help achieve financial balance'; another said 'top slice as per rest of council cut in % terms to cover other services'; another referred to 'rebadging to balance council budget, i.e. using grant to pay for services previously paid for by council'.

Reported changes include:

- 'Several new investments, efficiencies, renegotiation of contracts.'
- 'Significant disinvestment in a variety of programmes, including in particular sexual health services, and funding used to support early years services and 'floating support' preventive services in adult social care.'
- 'Staffing being restricted as budget seen as for services not specialist staff.'
- 'Major reorganisations of drugs, etc. and sexual health; savings being allocated to extending healthy free school meals and other food related projects, community mental health stuff including isolation/loneliness. Also some first year one-off savings to, for instance, support early help in children's social care.'
- 'Funds allocated to work on fuel and food.'
- 'Rebasing the budget for key programme areas and the development of new commissioning intentions.'
- 'Full schedule of service reviews and reprioritisation of the grant spend.'
- One respondent had agreed a fund to support public health activities at risk of reduction or removal.

### 5.3 Public availability of information on the allocation of the public health budget

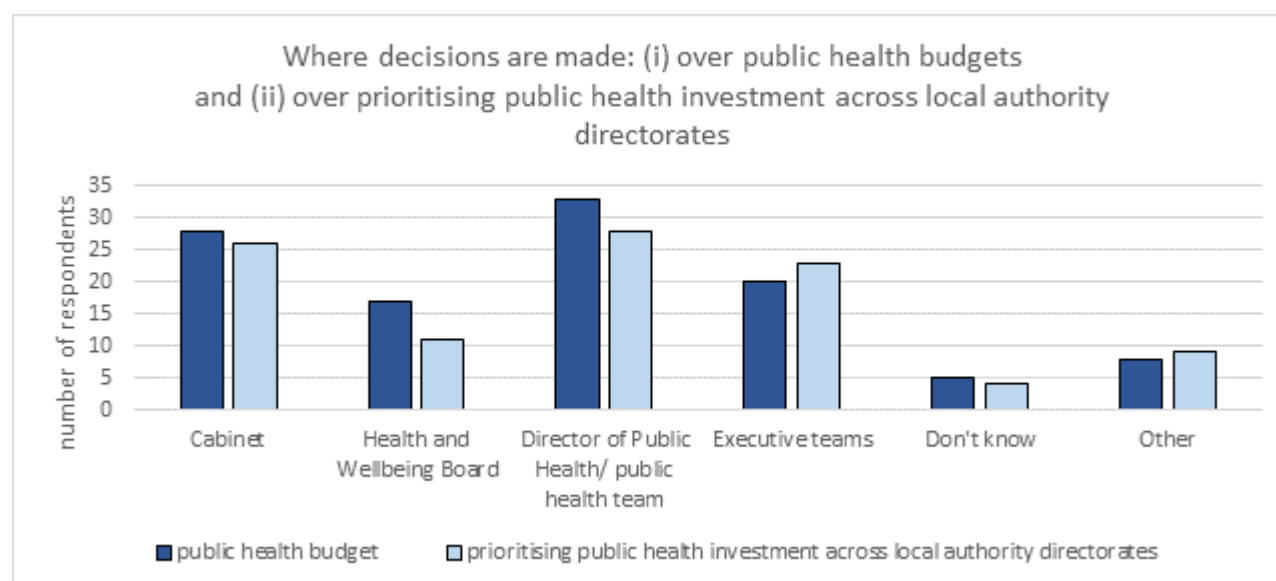
Nineteen of the respondents (40%) said the information on the budget allocation was publicly available, another said some was available, another said some information was available and two said it was nationally reported or had been made available through FOIs. 32% of respondents said it was not publicly available and 19% did not know.

## 6 Decision-making over priorities for expenditure on public health

### 6.1 Decision-making over priorities for the public health budget

Figure 11 shows responses to the two questions ‘in your host local authority, where are decisions made over priorities for the public health budget?’ and ‘in your host local authority, where are decisions made over prioritising public health investment across local authority directorates?’ The two questions generated very similar answers. The Director of Public Health and/or the public health team had the greatest decision-making responsibilities (and the bulk of respondents were also DsPH), followed by Cabinet then the Executive teams (please note that there are differences in terminology across councils). The decision-making powers of the HWBs rank lower than these.

Figure 11: where decisions are made

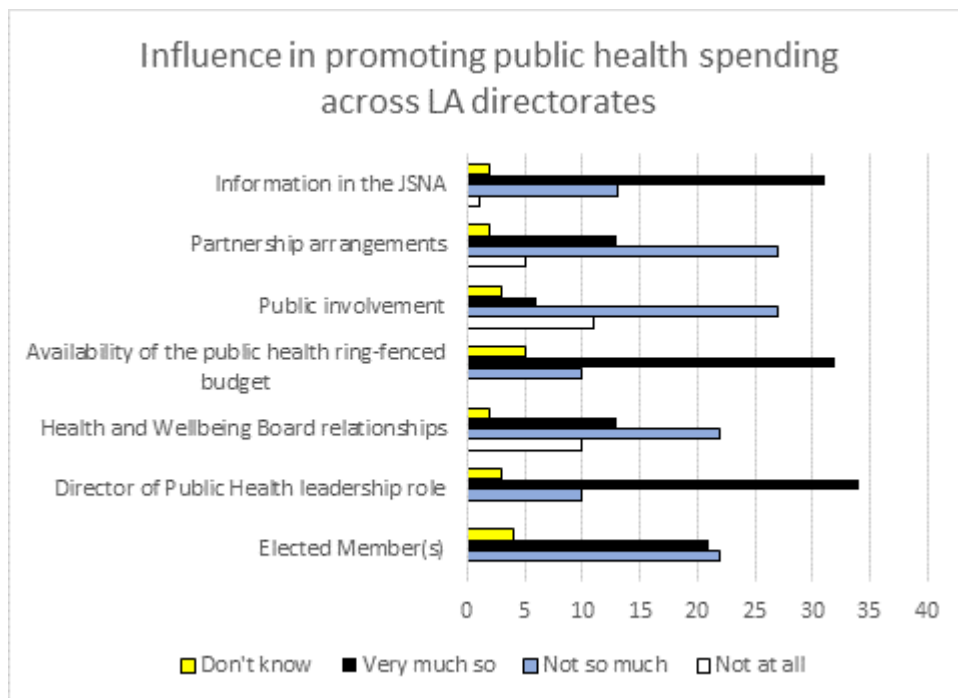


‘Other’ included county council health committee, director of corporate resources, CEO, all-party budget strategy group, assistant mayor for health and wellbeing.

### 6.2 Level of influence in promoting public health spending across local authority directorates

Respondents were asked how influential certain people or factors were in promoting public health spending across local authority directorates. As can be seen from Figure 12, the DPH leadership was felt by more people to be very influential (noting that DsPH formed the bulk of respondents), followed by the availability of the public health ring-fenced budget and the information in the JSNA. Partnership arrangements and public involvement were not thought to have much influence.

Figure 12: influence in promoting public health spending across local authority directorates

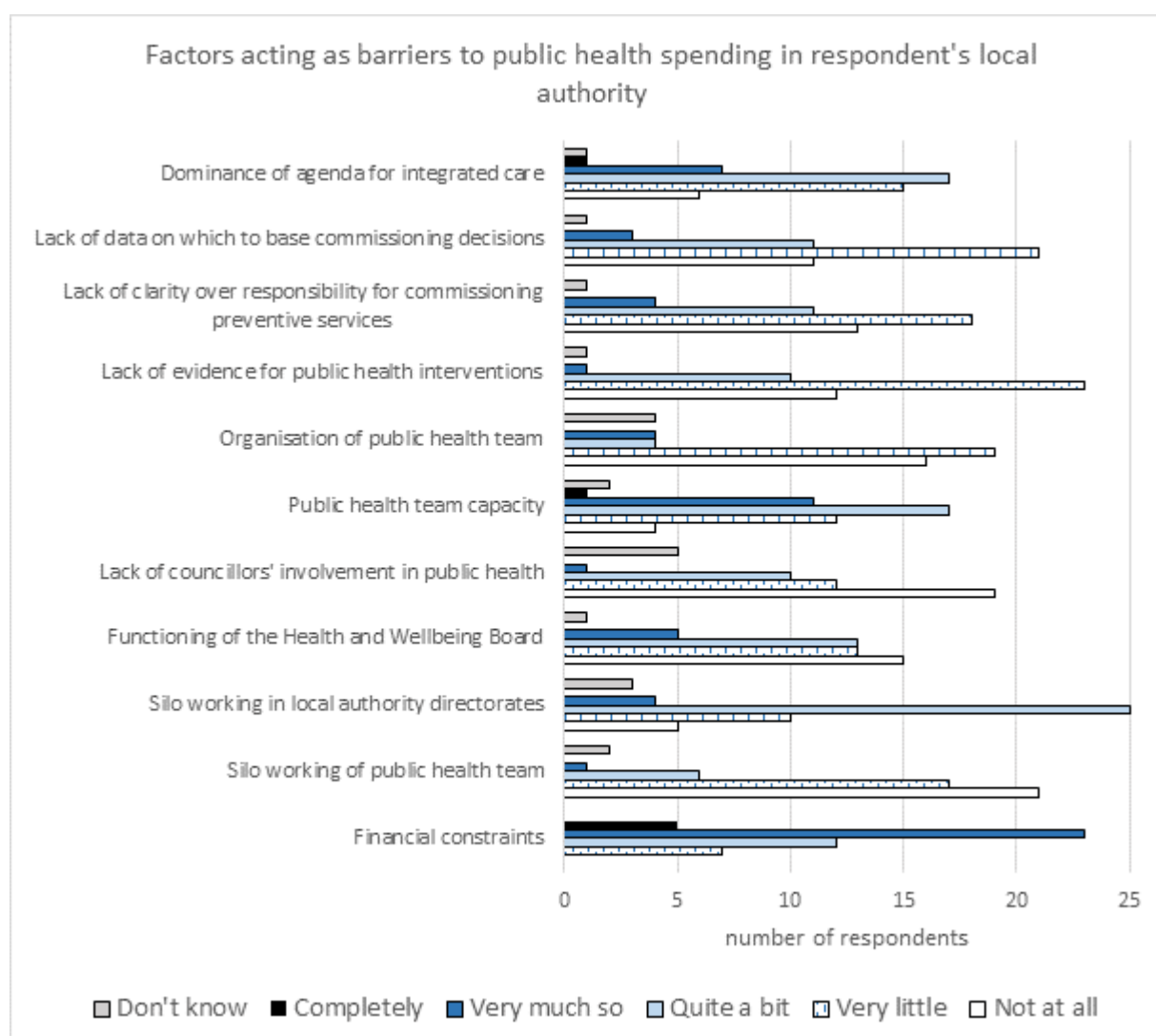


In the 'reflections on the survey' section, the differing viewpoints of local authorities were stressed by one respondent: 'unitaries and local authorities do see things differently but local government fixates on services not its population'.

## 7 Barriers to public health spending

Respondents were asked whether certain factors acted as barriers to public health spending in their local authority (see Figure 13). Silo working in local authority directorates was felt to be quite a barrier; only 40% of respondents felt this acted as very little or no barrier. Financial constraints were an important barrier, with only 15% of respondents believing they acted very little or not at all as a barrier. Factors that were generally not felt to be much of a barrier were: the functioning of the HWB; silo working of the public health team (note the contrast with silo working in local authority directorates); lack of councillors' involvement in public health (an interesting contrast with the feeling that the council or the cabinet or executive was responsible for most of the decision-making); organisation of the public health team (views on public health team capacity were very mixed); lack of evidence for public health interventions; lack of clarity over responsibility for commissioning preventive services; lack of data on which to base commissioning decisions. Views were split as to whether the dominance of the agenda for integrated care acted as a barrier.

Figure 13: factors acting as barriers to public health spending

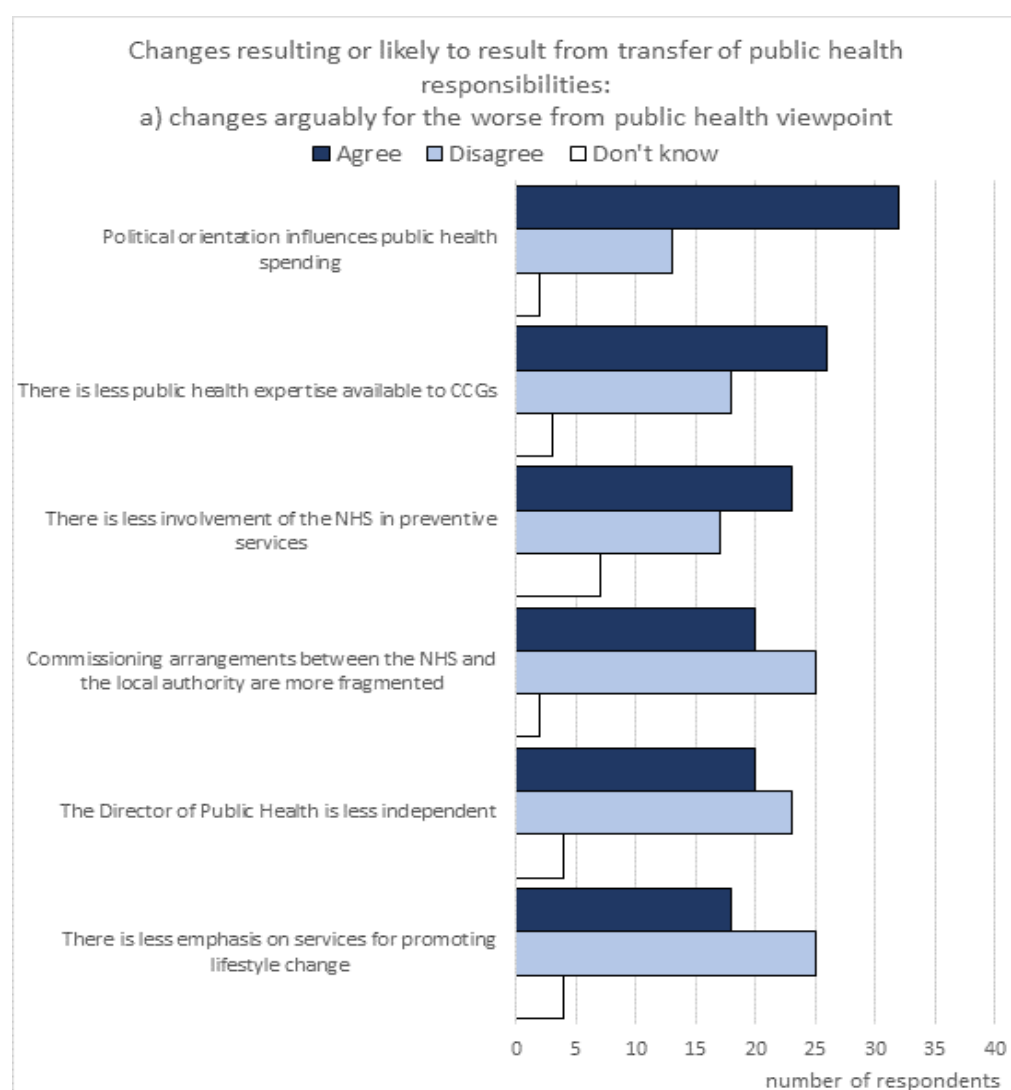


## 8 The effects of the transfer of public health responsibilities

Respondents were asked to consider which of a range of changes had resulted from or were likely to result from the transfer of public health responsibilities from the NHS to local authority. In the survey, each potential change was given as a simple statement, with no indication of whether or not this was a favourable change, and respondents simply had to state whether they agreed or disagreed with it. For ease of display and discussion, we have split the statements according to whether they might be seen as being for the better, for the worse, or either, from a public health viewpoint.

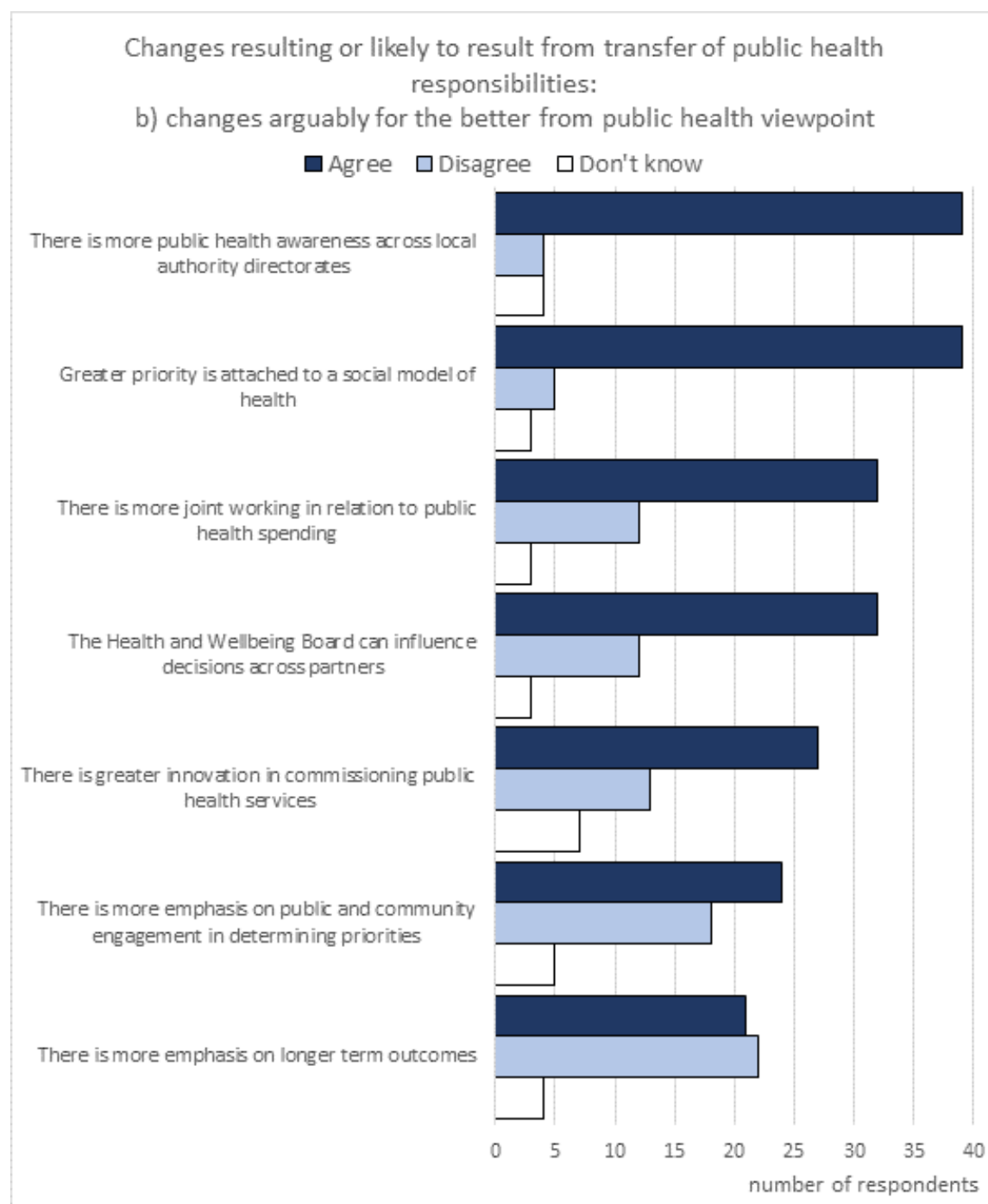
There was limited consensus with regard to the changes that might be regarded as being for the worse, as shown in Figure 14. Taking each statement in turn: 38% agreed that there is less emphasis on services for promoting lifestyle change (53% disagreed); 55% agreed that there is less public health expertise available to CCGs (38% disagreed); 43% agreed that commissioning arrangements between the NHS and local authority are more fragmented (53% disagreed); 49% agreed that there is less involvement of the NHS in preventive services (36% disagreed); 68% agreed that political orientation influences public health spending (28% disagreed); 43% agreed that the Director of Public Health is less independent (49% disagreed).

Figure 14: changes resulting from transfer of public health responsibilities – a) changes arguably for the worse from public health viewpoint



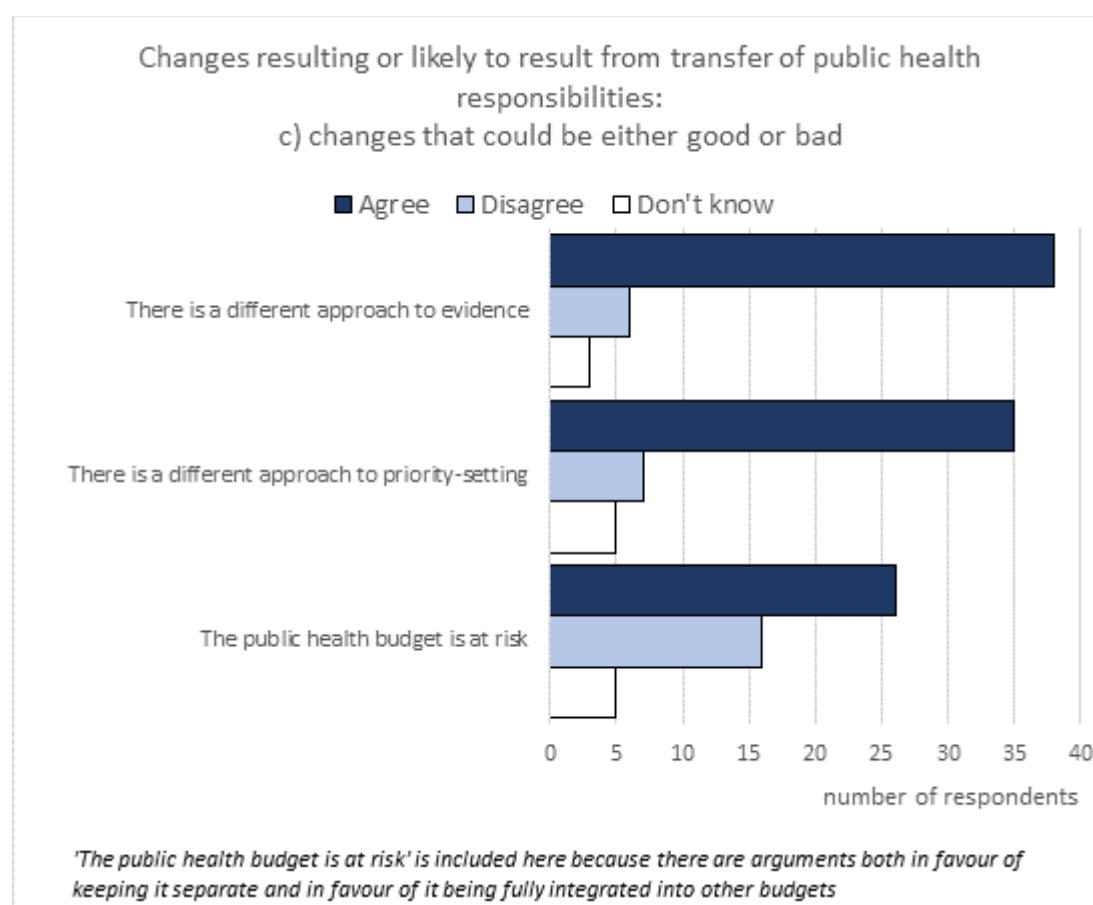
Looking at changes that might be regarded as being for the better, we can see from Figure 15 that the majority of respondents agreed that greater priority is attached to a social model of health (83% agreed); there is more public health awareness across local authority directorates (83% agreed), there is more joint working in relation to public health spending (68% agreed); the HWB can influence decisions across partners (68% agreed); there is greater innovation in commissioning public health services (57% agreed); and there is more emphasis on public and community engagement in determining priorities (51% agreed). With regard to longer term outcomes, 45% agreed and 47% disagreed that there is more emphasis on longer term outcomes.

Figure 15: changes resulting from transfer of public health responsibilities – b) changes arguably for the better from public health viewpoint



The remaining changes considered could be regarded as either beneficial or detrimental to public health (as shown in Figure 16). 55% of respondents agreed that the public health budget was at risk and 34 % disagreed. We have included this change in this section because there are arguments for a separate public health budget and arguments for a fully integrated budget, so it is not clear whether such a change would be for the better or for the worse. Whether changes to approaches to evidence or to priority-setting were good or bad was not addressed: 81% of respondents agreed that there was a different approach to evidence and 75% agreed that there was a different approach to priority-setting (15% disagreed).

Figure 16: changes resulting from transfer of public health responsibilities – c) changes that could be good or bad from public health viewpoint



In the 'reflections' section of the survey, one respondent said 'it is a very mixed message but we all get the feeling that things will get worse and services will reduce in the present political climate'. However, another said that 'the future for public health in local government is very uncertain in the short term - in the long term if it remains in local government it should eventually be a more cost-effective use of public sector spending on public health'.



## 9 Respondents' comments on the survey or topics covered

Respondents were offered the opportunity to comment on the survey or the topics covered in it.

Comments that were strongly related to specific survey questions have been included in the appropriate sections above.

Several comments relating to the survey layout or content concerned difficulties in answering question, some of which were felt to be ambiguous. The range of answer options was also criticised by some, who would have preferred scales rather than yes/no options in some cases and more nuancing to allow a better reflection of the complexity of the issues.

Eleven respondents said they would like to be kept informed of the progress of the project and 22 said they would not.


## 10 Limitations and strengths of the survey

We are aware of two particular limitations of the survey, which we feel means that its results have limited generalisability. The first is the low response rate, with only 47 responses from 610 invitations to respond (a rate of 7.7%). This was in spite of repeated attempts to remind invitees to complete the survey.

The second limitation is the high proportion of responses from Directors of Public Health, which might imply bias (26 respondents were Directors of Public Health, one was an assistant DPH and one a public health consultant, together accounting for 58% of responses). Health and Wellbeing Boards have members from a range of other departments or organisations. The next biggest contributor group was councillor/member or executive/cabinet member (eight in total).

The survey was not intended to be the sole source of information for the study on shifting the gravity of spending. It provides useful information to add to the findings of a series of workshops and in-depth interviews at three study sites. Findings are certainly not out of line with the findings of those more detailed studies.

The survey findings also suggest potential avenues of study for the follow-up research, which includes in-depth interviews and observation of priority-setting meetings in selected local authorities.



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